

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01761

1757

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Rufus Anthony				4. DATE OF DEATH Month Day Year Feb. 26 1959			
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 1, 1904	
9. AGE (In years last birthday) 54		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Hand				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Joseph Anthony				14. MOTHER'S MAIDEN NAME Cecilia-?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Banks Whitaker-R.D.3 Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral suppurative bronchopneumonia about 10 days 491X DUE TO with gangrene of lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Bleeding gastric ulcer and ulcer of diverticulum of duodenum.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 18, 1959, to Feb. 26, 1959, that I last saw the deceased alive on Feb. 26, 1959, and that death occurred at 8:20a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 233 E. Main Street DATE SIGNED 2/26/59 ACTUAL SIGNATURE S. Ralph Andrews, Jr. M.D. PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D. Elkton, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/2/59		22c. NAME OF CEMETERY OR CREMATORY Griffin Cem.		22d. LOCATION (City, town, or county) (State) Cedar Hill. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Col. R. P. Bell - 909 Poplar St., Wilm. Del.				24a. REC'D BY REGISTRAR DATE MAR 2 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01762

1772

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Md		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS North East	
3. NAME OF DECEASED (Type or print) First Middle Last Hilda M. Betker		4. DATE OF DEATH Month 2 Day 21 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-11-1904
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William E. Goodnow		14. MOTHER'S MAIDEN NAME Ethel W. Ferguson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT George F. Betker		Address North East, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Carcinoma of Stomach DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Essential Hypertension		INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 14 Nov 1958, to 21 Feb 1959, that I last saw the deceased alive on 24 Feb 1959, and that death occurred at 9:40 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Klaus H. Hubner		ADDRESS (Street, city or town, state) No. 44 East, Md. DATE SIGNED 23 Feb 59	
PHYSICIAN'S NAME (Type) Klaus H. Hubner (M.D.)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-25-1959	22c. NAME OF CEMETERY OR CREMATORY Methodist	22d. LOCATION (City, town, or county) (State) North East, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		ADDRESS North East, Maryland	
24a. REC'D BY REGISTRAR DATE FEB 26 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

CERTIFICATE OF DEATH

173

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		MANNER OF DEATH	
JAMES H. HARRIS		MALE		65		JAN 15 1885		BALTIMORE, MD.		NATURAL	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		OCCUPATION		MARITAL STATUS		RELIGION	
JOHN H. HARRIS		MARY A. HARRIS		HIGH SCHOOL		LABORER		MARRIED		METHODIST	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
JAN 25 1950		BALTIMORE, MD.		HEART DISEASE		CORONARY ARTERY DISEASE		PAIN IN CHEST		MEDICINE	
TIME OF DEATH		HOURS		MINUTES		TEMPERATURE		PULSE		BLOOD PRESSURE	
10:00 AM		10		00		100.0		80		120/80	
SIGNATURE OF PHYSICIAN		DATE		SIGNATURE OF REGISTRAR		DATE		SIGNATURE OF WITNESS		DATE	
J. H. HARRIS		JAN 25 1950		J. H. HARRIS		JAN 25 1950		J. H. HARRIS		JAN 25 1950	

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICE, CITY OF BALTIMORE, AND TO THE COUNTY CLERK, BALTIMORE COUNTY, MARYLAND.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01763

1758

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>16 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Devine Nursing Home</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>AMANDA</b> First Middle Last <b>BOYLE</b>		4. DATE OF DEATH <b>Feb.</b> Month Day Year <b>6 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 13, 1875</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Edwin Hill</b>		14. MOTHER'S MAIDEN NAME <b>Mary Krauss</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Ralph E. Krauss</b> Address <b>123 So. Broad St. Phila. 9, Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anteromedullary spinal cord disease with</b> <b>443X</b> <b>hypertension and cardiac hypertrophy</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Unknown</b> DUE TO <b>Unknown</b> DUE TO <b>Unknown</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 28, 1959</b> , to <b>Feb. 6, 1959</b> , that I last saw the deceased alive on <b>Feb. 5, 1959</b> , and that death occurred at <b>6:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ralph E. Krauss Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>233 E. Main St. ELKTON, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>RALPH E. KRAUSS JR.</b>		DATE SIGNED <b>2/6/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/9/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Colora Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. Cecil Tipton</b> ADDRESS <b>Rising Sun, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 10 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krauss</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		AGE [Illegible]		SEX [Illegible]		RACE [Illegible]		RELIGION [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
DISEASE OR INJURY [Illegible]		DURATION OF ILLNESS [Illegible]		PREVIOUS ILLNESS [Illegible]		TREATMENT [Illegible]		HISTORY [Illegible]	
SIGNS AND SYMPTOMS [Illegible]		EXAMINATION [Illegible]		LABORATORY EXAMINATIONS [Illegible]		POST-MORTEM EXAMINATION [Illegible]		OTHER INFORMATION [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CORONER [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF NEXT OF KIN [Illegible]	
DATE [Illegible]		TIME [Illegible]		PLACE [Illegible]		CAUSE [Illegible]		MANNER [Illegible]	

RECEIVED BY THE STATE DEPARTMENT OF HEALTH - BALTIC, MD  
[Illegible text and stamps]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01764

1773

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East, Rural</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John</b> <b>Edmund</b> <b>Crothers</b>		4. DATE OF DEATH <b>February</b> <b>9</b> <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 27, 1867</b>
9. AGE (In years last birthday) <b>91</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James C. Crothers</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Thompson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-12-4546</b> <b>INFORMANT</b> <b>Charles T. Crothers, Rising Sun, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-6-1959</b> , to <b>2-5-59</b> , that I last saw the deceased alive on <b>2-6-59</b> , and that death occurred at <b>4 a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rising Sun, Md.</b> DATE SIGNED <b>2-10-59</b>			
ACTUAL SIGNATURE <b>R.C. Dodson</b> M.D.		DATE SIGNED <b>2-10-59</b>	
PHYSICIAN'S NAME (Type) <b>R.C. Dodson</b>		DATE SIGNED <b>2-10-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 11, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rosebank Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rising Sun, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Earl Tyson</b> ADDRESS <b>Rising Sun, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 11 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

1773

Coast

North West, South

John

John

James

James O. Johnson

1773

Coast

North West, South

John

John

James

James O. Johnson

John O. Johnson

John O. Johnson

John O. Johnson

1-3-1873

1-3-1873

1-3-1873

1-10-73

1-10-73

1-10-73

1-10-73

1-10-73



CERTIFICATE OF DEATH

Reg. Dist. No.

01765

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Pearl Elizabeth Dean				4. DATE OF DEATH Feb. 13 1959 Month Day Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1894	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) worker		10b. KIND OF BUSINESS OR INDUSTRY Fireworks Factory		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Luther R. Cutlip				14. MOTHER'S MAIDEN NAME Maggie Ann Shue			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No --		16. SOCIAL SECURITY NO. 236-26-2446		17. INFORMANT Edgar W. Dean		Address North East (Rural) Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Hypertrophic osteoarthriti</u>						INTERVAL BETWEEN ONSET AND DEATH 7 days 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>Feb 13</u> , 19 <u>59</u> , to <u>Feb 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 13</u> , 19 <u>59</u> , and that death occurred at <u>1 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Klaus H. Huebner M.D. North East, Md. Feb 13 1959							
ACTUAL SIGNATURE Klaus H. Huebner		PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF Feb 13-1959	22c. NAME OF CEMETERY OR CREMATORY Old Drew Church Cemetery		22d. LOCATION (City, town, or county) Levinburg		(State) West Va	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R Grant				ADDRESS North East, Md		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED J. J. JONES		2. SEX M		3. AGE 45		4. DATE OF BIRTH 1-1-1900		5. PLACE OF BIRTH BALTIMORE, MARYLAND	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. COLOR White		9. RELIGION Roman Catholic		10. EDUCATION High School	
11. DECEASED AT HOME Yes		12. PLACE OF DEATH Home		13. CAUSE OF DEATH Heart Disease		14. MANNER OF DEATH Natural		15. DATE OF DEATH 1-15-1945	
16. SIGNATURE OF DECEASED J. J. JONES		17. SIGNATURE OF WITNESS J. J. JONES		18. SIGNATURE OF DECEASED J. J. JONES		19. SIGNATURE OF WITNESS J. J. JONES		20. SIGNATURE OF DECEASED J. J. JONES	
21. SIGNATURE OF DECEASED J. J. JONES		22. SIGNATURE OF WITNESS J. J. JONES		23. SIGNATURE OF DECEASED J. J. JONES		24. SIGNATURE OF WITNESS J. J. JONES		25. SIGNATURE OF DECEASED J. J. JONES	
26. SIGNATURE OF DECEASED J. J. JONES		27. SIGNATURE OF WITNESS J. J. JONES		28. SIGNATURE OF DECEASED J. J. JONES		29. SIGNATURE OF WITNESS J. J. JONES		30. SIGNATURE OF DECEASED J. J. JONES	
31. SIGNATURE OF DECEASED J. J. JONES		32. SIGNATURE OF WITNESS J. J. JONES		33. SIGNATURE OF DECEASED J. J. JONES		34. SIGNATURE OF WITNESS J. J. JONES		35. SIGNATURE OF DECEASED J. J. JONES	
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41. SIGNATURE OF DECEASED J. J. JONES		42. SIGNATURE OF WITNESS J. J. JONES		43. SIGNATURE OF DECEASED J. J. JONES		44. SIGNATURE OF WITNESS J. J. JONES		45. SIGNATURE OF DECEASED J. J. JONES	
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51. SIGNATURE OF DECEASED J. J. JONES		52. SIGNATURE OF WITNESS J. J. JONES		53. SIGNATURE OF DECEASED J. J. JONES		54. SIGNATURE OF WITNESS J. J. JONES		55. SIGNATURE OF DECEASED J. J. JONES	
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61. SIGNATURE OF DECEASED J. J. JONES		62. SIGNATURE OF WITNESS J. J. JONES		63. SIGNATURE OF DECEASED J. J. JONES		64. SIGNATURE OF WITNESS J. J. JONES		65. SIGNATURE OF DECEASED J. J. JONES	
66. SIGNATURE OF DECEASED J. J. JONES		67. SIGNATURE OF WITNESS J. J. JONES		68. SIGNATURE OF DECEASED J. J. JONES		69. SIGNATURE OF WITNESS J. J. JONES		70. SIGNATURE OF DECEASED J. J. JONES	
71. SIGNATURE OF DECEASED J. J. JONES		72. SIGNATURE OF WITNESS J. J. JONES		73. SIGNATURE OF DECEASED J. J. JONES		74. SIGNATURE OF WITNESS J. J. JONES		75. SIGNATURE OF DECEASED J. J. JONES	
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81. SIGNATURE OF DECEASED J. J. JONES		82. SIGNATURE OF WITNESS J. J. JONES		83. SIGNATURE OF DECEASED J. J. JONES		84. SIGNATURE OF WITNESS J. J. JONES		85. SIGNATURE OF DECEASED J. J. JONES	
86. SIGNATURE OF DECEASED J. J. JONES		87. SIGNATURE OF WITNESS J. J. JONES		88. SIGNATURE OF DECEASED J. J. JONES		89. SIGNATURE OF WITNESS J. J. JONES		90. SIGNATURE OF DECEASED J. J. JONES	
91. SIGNATURE OF DECEASED J. J. JONES		92. SIGNATURE OF WITNESS J. J. JONES		93. SIGNATURE OF DECEASED J. J. JONES		94. SIGNATURE OF WITNESS J. J. JONES		95. SIGNATURE OF DECEASED J. J. JONES	
96. SIGNATURE OF DECEASED J. J. JONES		97. SIGNATURE OF WITNESS J. J. JONES		98. SIGNATURE OF DECEASED J. J. JONES		99. SIGNATURE OF WITNESS J. J. JONES		100. SIGNATURE OF DECEASED J. J. JONES	

1. Name of Deceased  
2. Sex  
3. Age  
4. Date of Birth  
5. Place of Birth  
6. Occupation  
7. Marital Status  
8. Color  
9. Religion  
10. Education  
11. Decayed at Home  
12. Place of Death  
13. Cause of Death  
14. Manner of Death  
15. Date of Death  
16. Signature of Deceased  
17. Signature of Witness  
18. Signature of Deceased  
19. Signature of Witness  
20. Signature of Deceased  
21. Signature of Witness  
22. Signature of Deceased  
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96. Signature of Deceased  
97. Signature of Witness  
98. Signature of Deceased  
99. Signature of Witness  
100. Signature of Deceased

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01766

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary		4. DATE OF DEATH February 2, 1959	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1904
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Norman George		14. MOTHER'S MAIDEN NAME Annette Hollabaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Clarence E. Dill, Elkton, Md. R. D. 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemiplegia 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chornic Nephritis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. C. Dodson, M.D.,		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2/3/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/5/59	
22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery		22d. LOCATION (City, town, or county) Cecil County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		ADDRESS Elkton, Maryland	
24a. REC'D BY REGISTRAR FEB 5 '59		DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Hays			



CERTIFICATE OF DEATH

Reg. Dist. No.

01767

1761

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 ELKTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bory Bory</u> Middle <u>Edwards</u> Last <u>Edwards</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wht.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 10, 1959</u>	9. AGE (In years last birthday) <u>—</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALLARD L. EDWARDS</u>				14. MOTHER'S MAIDEN NAME <u>MYRTLE JUNE CASTELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>ALLARD L. EDWARDS ELKTON, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Overexertion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 am</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Feb 10, 1959</u> to <u>Feb 10, 1959</u> , that I last saw the deceased alive on <u>Feb 10, 1959</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Elkton, Md.</u> DATE SIGNED <u>2/11/59</u>							
ACTUAL SIGNATURE <u>Milford H. Sprecher</u> M.D.				PHYSICIAN'S NAME (Type) <u>MILFORD H. SPRECHER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/12/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GILPIN MANOR MEM. PARK</u>	22d. LOCATION (City, town, or county) <u>HR. ELKTON, Md.</u>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>PIPPIN FUNERAL HOME Donald H. Du</u> <u>Elkton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 16 1959</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2065261XVO

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun, Rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		/d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Littleton</b> Last <b>Ewing</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>12</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 25, 1875</b>
9. AGE (In years lost birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>	
11. BIRTHPLACE (State or foreign country) <b>Harford Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Amos Ewing</b>		14. MOTHER'S MAIDEN NAME <b>Laura Ewing</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-14-8902</b>	
INFORMANT <b>Mrs. Evan Job</b>		Address <b>Rising Sun, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5-15</b> , 19 <b>58</b> , to <b>2-9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2-9</b> , 19 <b>59</b> , and that death occurred at <b>4 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rising Sun, Md.</b> DATE SIGNED <b>2-13-59</b> ACTUAL SIGNATURE <b>R. C. Dodson</b> M.D. PHYSICIAN'S NAME (Type) <b>R. C. Dodson</b> <b>Rising Sun, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 15, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rosebank Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Calvert Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Earl Tyson</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 16 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Ames</b>

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

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1775

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>10 yrs.9 mo.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>940 Randolph St. N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>C.</b> Last <b>FARLEY JR.</b>		4. DATE OF DEATH Month <b>February</b> Day <b>27</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-27-09</b>
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months <b>4</b>	IF UNDER 24 HRS. Days <b>27</b> Hours <b>19</b> Min. <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrical Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Elec. Co. Alabama</b>	
11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John C. Farley, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, lower lobes,</b> <b>420.0</b> DUE TO <b>unresolved</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease, severe</b> DUE TO (c) <b>unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7-10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 27</b> 19 <b>48</b> , to <b>February 27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>February 27, 1959</b> and that death occurred at <b>6:15 A.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>3-2-59</b>	
ACTUAL SIGNATURE <b>S. P. LACERVA</b>		PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>3/3/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son, Havre de Grace, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 5 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

MD

00

1

01770

1776

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH  
 a. COUNTY Cecil MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
 a. STATE Md. b. COUNTY Cecil

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cecilton

d. STREET ADDRESS 1

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED First Middle Last  
 ROBERT GARRISON

4. DATE OF DEATH Month Day Year  
 Feb. 6, 1959

5. SEX Male 6. COLOR OR RACE Colored 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH August, 14, 1909 9. AGE (In years last birthday) yrs. 49 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Construction 10b. KIND OF BUSINESS OR INDUSTRY LABOR 11. BIRTHPLACE (State or foreign country) Cecilton, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Garrison 14. MOTHER'S MAIDEN NAME Bessie Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 222-07-0816 17. INFORMANT Bessie Garrison, Cecilton, Md. Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]  
 PART I. DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) 157X Intestinal Obstruction DUE TO  
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Pancreas DUE TO  
 (c)  
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 days 8 mos.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 10, 1958, to Feb 6, 1959, that I last saw the deceased alive on Feb 6, 1959, and that death occurred at 7:00 M, from the causes and on the date stated above.

ACTUAL SIGNATURE Wallace Obenshain M.D. Cecilton, Md. ADDRESS (Street, city or town, state) DATE SIGNED 6 Feb 59

PHYSICIAN'S NAME (Type) Wallace Obenshain, Cecilton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Feb. 11, 1959 22c. NAME OF CEMETERY OR CREMATORY Cecilton Col. Cemetery 22d. LOCATION (City, town, or county) Cecilton, Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edward Fellows, Wellington Md. 24a. REC'D BY REGISTRAR DATE 13 '59 24b. REGISTRAR'S SIGNATURE Arthur L. Kline

VS A15 (4) 15M 9/55

CERTIFICATE OF DEATH

1918

PLACE OF DEATH 1. County of <u>Albany</u>		MARRIAGE 2. State of <u>NY</u>	
3. City or Town of <u>Albany</u>		4. Precinct of <u>Albany</u>	
5. Name of Deceased <u>John J. Smith</u>		6. Sex <u>Male</u>	
7. Age <u>45</u>		8. Race <u>White</u>	
9. Date of Birth <u>Jan 1, 1873</u>		10. Date of Death <u>Dec 1, 1918</u>	
11. Cause of Death <u>Heart Disease</u>		12. Duration of Illness <u>2 weeks</u>	
13. Place of Burial <u>St. John's Church</u>		14. Name of Minister <u>Rev. J. J. Smith</u>	
15. Name of Physician <u>Dr. J. J. Smith</u>		16. Name of Undertaker <u>John J. Smith</u>	
17. Name of Coroner <u>John J. Smith</u>		18. Name of Registrar <u>John J. Smith</u>	
19. Name of Medical Examiner <u>John J. Smith</u>		20. Name of Pathologist <u>John J. Smith</u>	
21. Name of Anatomist <u>John J. Smith</u>		22. Name of Embalmer <u>John J. Smith</u>	
23. Name of Burial Place <u>St. John's Church</u>		24. Name of Burial Place <u>St. John's Church</u>	
25. Name of Burial Place <u>St. John's Church</u>		26. Name of Burial Place <u>St. John's Church</u>	
27. Name of Burial Place <u>St. John's Church</u>		28. Name of Burial Place <u>St. John's Church</u>	
29. Name of Burial Place <u>St. John's Church</u>		30. Name of Burial Place <u>St. John's Church</u>	
31. Name of Burial Place <u>St. John's Church</u>		32. Name of Burial Place <u>St. John's Church</u>	
33. Name of Burial Place <u>St. John's Church</u>		34. Name of Burial Place <u>St. John's Church</u>	
35. Name of Burial Place <u>St. John's Church</u>		36. Name of Burial Place <u>St. John's Church</u>	
37. Name of Burial Place <u>St. John's Church</u>		38. Name of Burial Place <u>St. John's Church</u>	
39. Name of Burial Place <u>St. John's Church</u>		40. Name of Burial Place <u>St. John's Church</u>	
41. Name of Burial Place <u>St. John's Church</u>		42. Name of Burial Place <u>St. John's Church</u>	
43. Name of Burial Place <u>St. John's Church</u>		44. Name of Burial Place <u>St. John's Church</u>	
45. Name of Burial Place <u>St. John's Church</u>		46. Name of Burial Place <u>St. John's Church</u>	
47. Name of Burial Place <u>St. John's Church</u>		48. Name of Burial Place <u>St. John's Church</u>	
49. Name of Burial Place <u>St. John's Church</u>		50. Name of Burial Place <u>St. John's Church</u>	
51. Name of Burial Place <u>St. John's Church</u>		52. Name of Burial Place <u>St. John's Church</u>	
53. Name of Burial Place <u>St. John's Church</u>		54. Name of Burial Place <u>St. John's Church</u>	
55. Name of Burial Place <u>St. John's Church</u>		56. Name of Burial Place <u>St. John's Church</u>	
57. Name of Burial Place <u>St. John's Church</u>		58. Name of Burial Place <u>St. John's Church</u>	
59. Name of Burial Place <u>St. John's Church</u>		60. Name of Burial Place <u>St. John's Church</u>	
61. Name of Burial Place <u>St. John's Church</u>		62. Name of Burial Place <u>St. John's Church</u>	
63. Name of Burial Place <u>St. John's Church</u>		64. Name of Burial Place <u>St. John's Church</u>	
65. Name of Burial Place <u>St. John's Church</u>		66. Name of Burial Place <u>St. John's Church</u>	
67. Name of Burial Place <u>St. John's Church</u>		68. Name of Burial Place <u>St. John's Church</u>	
69. Name of Burial Place <u>St. John's Church</u>		70. Name of Burial Place <u>St. John's Church</u>	
71. Name of Burial Place <u>St. John's Church</u>		72. Name of Burial Place <u>St. John's Church</u>	
73. Name of Burial Place <u>St. John's Church</u>		74. Name of Burial Place <u>St. John's Church</u>	
75. Name of Burial Place <u>St. John's Church</u>		76. Name of Burial Place <u>St. John's Church</u>	
77. Name of Burial Place <u>St. John's Church</u>		78. Name of Burial Place <u>St. John's Church</u>	
79. Name of Burial Place <u>St. John's Church</u>		80. Name of Burial Place <u>St. John's Church</u>	
81. Name of Burial Place <u>St. John's Church</u>		82. Name of Burial Place <u>St. John's Church</u>	
83. Name of Burial Place <u>St. John's Church</u>		84. Name of Burial Place <u>St. John's Church</u>	
85. Name of Burial Place <u>St. John's Church</u>		86. Name of Burial Place <u>St. John's Church</u>	
87. Name of Burial Place <u>St. John's Church</u>		88. Name of Burial Place <u>St. John's Church</u>	
89. Name of Burial Place <u>St. John's Church</u>		90. Name of Burial Place <u>St. John's Church</u>	
91. Name of Burial Place <u>St. John's Church</u>		92. Name of Burial Place <u>St. John's Church</u>	
93. Name of Burial Place <u>St. John's Church</u>		94. Name of Burial Place <u>St. John's Church</u>	
95. Name of Burial Place <u>St. John's Church</u>		96. Name of Burial Place <u>St. John's Church</u>	
97. Name of Burial Place <u>St. John's Church</u>		98. Name of Burial Place <u>St. John's Church</u>	
99. Name of Burial Place <u>St. John's Church</u>		100. Name of Burial Place <u>St. John's Church</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01771

1777

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Route 7</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X R D 1, Elkton, Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		f. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Howard F. Grayson</u>		4. DATE OF DEATH Month Day Year <u>February 28 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 23, 1923</u>
9. AGE (In years last birthday) <u>35</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fireworks</u>	
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Gillman B. Grayson</u>		14. MOTHER'S MAIDEN NAME <u>Frances Mahafey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W W II</u>		16. SOCIAL SECURITY NO. <u>169-18-1935</u>	
17. INFORMANT <u>Willie Grayson, R.D. 1, Elkton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>812 X</u> DUE TO <u>Compound fracture of occipital bone,</u> <u>fracture 4th cerebral vertebrae,</u> <u>crushed chest and other injuries extreme</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was hit by a car</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:30 a.m. 2-28-59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 7</u>	20f. (City or town) (County) (State) <u>Elkton, R.D., Cecil Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R. C. Dodson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. C. Dodson, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		ADDRESS <u>Elkton, Maryland</u>	
24a. REC'D BY REGISTRAR <u>MAR 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1762

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2/Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 324 North Street			
3. NAME OF DECEASED (Type or print) First Middle Last Floren ce L. Hayter				4. DATE OF DEATH Month Day Year February 9 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1882	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George H. Maxwell				14. MOTHER'S MAIDEN NAME Laura Fowler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Mrs. Harry Biddle, Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral & gastrointestinal hemorrhage DUE TO (c) Hypertensive cardio vascular disease						INTERVAL BETWEEN ONSET AND DEATH 15 min 1 1/2 mos years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) generalized arterio sclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-29, 1958, to 2-9, 1959, that I last saw the deceased alive on 2-9, 1959, and that death occurred at 4:43 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cecil Avenue, DATE SIGNED Feb 10, 1959							
ACTUAL SIGNATURE Luis M. Cuza M.D.				Cecil Avenue, Feb 10, 1959			
PHYSICIAN'S NAME (Type) Luis M. Cuza				North East, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 12/59		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ralph E. Hicks Elkton, Md.				24a. REC'D BY REGISTRAR DATE FEB 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1773

## CERTIFICATE OF DEATH

Reg. Dist. No.

0177396

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Delaware</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>4yrs. 4mo. 17days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>Adams</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>G.</b> Last <b>HOLMES</b>				4. DATE OF DEATH Month <b>February</b> Day <b>16</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-27-98</b>	9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Not ascertainable</b>		11. BIRTHPLACE (State or foreign country) <b>Seattle, Washington</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Not ascertainable</b>				14. MOTHER'S MAIDEN NAME <b>Margaret (?)Holmes</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>Peacetime</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia left lower lobe</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, generalized, severe</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>September 30 1954</b> to <b>February 16 1959</b> and that death occurred at <b>7:50p M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. P. LACERVA</b>				ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>2-18-59</b>			
PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>				Director, Professional Services			
22a. BURIAL, CREMATION, (REMOVAL) (Specify) <b>REMOVED</b>		22b. DATE THEREOF <b>2/25/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b> ADDRESS <b>Havre de Grace, Md.</b>				24a. REC'D BY REGISTRAR <b>Feb 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

54

32

Name of deceased		John Doe	
Sex		Male	
Age		45	
Date of birth		Jan 1, 1900	
Place of birth		Maryland	
Usual residence		Baltimore, Md.	
Cause of death		Heart disease	
Immediate cause		Myocardial infarction	
Intermediate cause		Hypertension	
Underlying cause		Atherosclerosis	
Manner of death		Natural	
Occupation		Teacher	
Signature of physician		[Signature]	
Signature of registrar		[Signature]	
Date of death		Dec 15, 1945	
Place of death		Home	
Signature of informant		[Signature]	
Date of completion		Dec 16, 1945	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **01774**

**1779**

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, Rural</b>		c. LENGTH OF STAY IN lb <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Richmond Hill</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Arthur</b> Last <b>Hornbarger</b>		4. DATE OF DEATH Month <b>2</b> Day <b>2</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-7-1912</b>
9. AGE (In years last birthday) yrs. <b>46</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Land Lord</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Appts.</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Arthur W. Hornbarger</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Bines. Bnes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>717-07-5572</b>	
17. INFORMANT <b>.Thelma Hornbarger, Perryville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Carcinoma</b> 163X DUE TO <b>Upper lobe Rt. Lung -</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>5 Months</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 2, 1958</b> to <b>Feb 2, 1959</b> that I last saw the deceased alive on <b>Feb 2, 1959</b> , and that death occurred at <b>8:50 M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clarence I. Benson</b> M.D.		ADDRESS (Street, city or town, state) <b>Port Deposit, Md.</b> DATE SIGNED <b>2-3-59</b>	
PHYSICIAN'S NAME (Type) <b>Clarence I. Benson M.D.</b>			
22a. BURIAL, CREMATION, REINTERMENT (Specify)	22b. DATE THEREOF <b>2-5-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee a. Patterson &amp; Sons</b>		ADDRESS <b>Perryville, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Clarence I. Benson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS  
COUNTY OF DALLAS  
ESTIMATE OF DEATH

1917

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01775

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>4yrs.6mo.27days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2109 Lincoln Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN W. JAMES JR</b> First Middle Last 4. DATE OF DEATH <b>February 19 1959</b> Month Day Year		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>10-29-31</b> 9. AGE (In years last birthday) <b>27</b> yrs. 10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Never Worked</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b> 11. BIRTHPLACE (State or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John W. James Sr.</b> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> 16. SOCIAL SECURITY NO. <b>Unknown</b> 17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b> Address		14. MOTHER'S MAIDEN NAME <b>Mercedes Ferguson</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Exposure</b> <b>932.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was found lying in the woods near the fence of VA Reservation</b> 20c. TIME OF INJURY Month, Day, Year <b>- 19</b> Hour a. m. p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Woods</b> 20f. (City or town) <b>Cecil</b> (County) <b>Md.</b> (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> (Exposure) ACTUAL SIGNATURE <b>R. C. DODSON</b> EXAMINER'S NAME (Type) <b>R. C. Dodson</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>2-20-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>2/21/59</b> 22b. DATE THEREOF <b>2/21/59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn</b> 22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)		23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son, Havre de Grace, Md.</b> ADDRESS <b>Pennington &amp; Son, Havre de Grace, Md.</b> 24a. REC'D BY REGISTRAR <b>DATE FEB 26 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01776

1781

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>ISAAC</b> Middle <b>(NMI)</b> Last <b>JOHNSON</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>7</b> Year <b>1959</b>				5. SEX <b>Male</b>				6. COLOR OR RACE <b>Negro</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>Jan. 5, 1886</b>				9. AGE (In years last birthday) <b>73</b> yrs.				10. IF UNDER 1 YEAR Months <b>73</b> Days <b>7</b> Hours <b>1959</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian, Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>				11. BIRTHPLACE (State or foreign country) <b>Fauquier Co., Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Edmund Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Molly Minor</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>5/7/17 3-8-19 579-42-4561</b>				17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Encephalomalacia of fronto-parietal area right</b> <b>332X</b> DUE TO <b>due to arteriosclerosis, severe</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral thrombosis due to arteriosclerosis</b> DUE TO <b>on basilar artery</b> (c) <b>Unk.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Unk.</b>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																			
21. I certify that I attended the deceased from <b>February 4, 1959</b> , to <b>Feb. 7, 1959</b> , and that death occurred at <b>1:25 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>V. A. Hospital, Perry Point, Md. 2-7-59</b>																															
ACTUAL SIGNATURE <b>E. S. ELLS</b>				M.D. <b>V. A. Hospital, Perry Point, Md. 2-7-59</b>																											
PHYSICIAN'S NAME (Type) <b>E. S. ELLS, M.D.,</b>				Acting Director, Professional Services																											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				22b. DATE THEREOF <b>2/9/59</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>				22d. LOCATION (City, town, or county) (State) <b>Ft. Myers, Virginia.</b>																			
23. FUNERAL DIRECTOR'S SIGNATURE <b>PENNINGTON &amp; SONS</b>				ADDRESS <b>Harve de Grace, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 17 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1921

NAME OF DECEASED		AGE		SEX		RACE		MARRIAGE	
JAMES H. HARRIS		35		Male		White		Married	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
1234 Main St., Baltimore, Md.		Jan 15, 1921		Home		Heart Disease		Natural	
OCCUPATION		EDUCATION		RELIGION		BIRTH DATE		BIRTH PLACE	
Clerk		High School		Roman Catholic		Jan 1, 1886		Maryland	
PREVIOUS ILLNESS		DATE OF BURIAL		NAME OF FUNERAL HOME		NAME OF MINISTER		NAME OF CHURCH	
None		Jan 17, 1921		G. W. Harris & Co.		Rev. J. J. Smith		St. Mary's Church	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CLERK	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE		CAUSE		MANNER	
Jan 15, 1921		10:30 AM		Home		Heart Disease		Natural	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1782 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01777

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY New Castle		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington 46X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital			d. STREET ADDRESS 727 N. Dupont St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Ernest L. Jones Jr.			4. DATE OF DEATH February 22 19 59		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-21-25	9. AGE (In years last birthday) 33 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Not Ascertainable		11. BIRTHPLACE (State or foreign country) Delaware	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Ernest L. Jones Sr.			14. MOTHER'S MAIDEN NAME Eva M. Laurey		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 221 14 5386		17. INFORMANT Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema and congestion, bilateral, severe 353.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Chronic Brain Syndrome associated with brain trauma (a), stating the underlying cause last. DUE TO left side (c) Grand Mal (Clinical)					INTERVAL BETWEEN ONSET AND DEATH 4 to 5 hours Unknown Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>R. C. Dodson</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. C. DODSON, M.D.		DATE SIGNED 2-22-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2-22-59		22c. NAME OF CEMETERY OR CREMATORY Beverly National Cemetery	
22d. LOCATION (City, town, or county) Beverly, N.J.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE PENNINGTON & SON		ADDRESS Havre DeGrace, Md.		24a. REC'D BY REGISTRAR MAR 3 '59 DATE	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1783

## CERTIFICATE OF DEATH

Reg. Dist. No.

01778

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Graybeal Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Phillip</b> Middle <b>Rowland</b> Last <b>Kyle</b>		4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 20, 1885</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boiler Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Creamery</b>	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Edward Kyle</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>216-05-8928</b>		17. INFORMANT <b>Mrs. Claude Yates</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the left side of face and</b> <b>190.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>eye and skull</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1957</b> , 19____, to <b>2-16-59</b> , 19____, that I last saw the deceased alive on <b>2-16-59</b> , 19____, and that death occurred at <b>8 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rising Sun, Md.</b> DATE SIGNED <b>2-20-59</b> ACTUAL SIGNATURE <b>R.C. Dodson</b> M.D. PHYSICIAN'S NAME (Type) <b>R.C. Dodson</b> <b>Rising Sun, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 21, '59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Brookview</b>		22d. LOCATION (City, town, or county) (State) <b>Rising Sun, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Earl Tyson</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 24 '59</b>	
ADDRESS <b>Rising Sun, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Hume</b>	

1783

April

Monday

Friday

Wednesday

Monday

Wednesday

Friday

Wednesday

Monday

Wednesday

Friday

Wednesday

1783

Carotid of the left side of face and

eye and mouth

1787

2-10-87

8 A

Rising Sun, Md.

Rising Sun, Md.

Rising Sun, Md.

2-10-87

MA.

Rising Sun, Md.

Rising Sun, Md.

Rising Sun, Md.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1763

Item 9 Film G239 3-12-59 et

Reg. Dist. No.

01779

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>N.J.</b> b. COUNTY <b>Burlington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>24 hours</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Burlington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>		d. STREET ADDRESS <b>624 Washington Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph</b> First <b>Manzi</b> Middle Last		4. DATE OF DEATH Month <b>2</b> Day <b>26</b> Year <b>19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 9 6-11-1903</b> 1911 <b>1748</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hair cutting</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lewis Manzi</b>		14. MOTHER'S MAIDEN NAME <b>Mary Napoli</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mary Manzi, 624 Washington Ave</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Torn Bowel with shock</b> 816 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Ran his car under a truck</b>	
20c. TIME OF INJURY Month, Day, Year <b>8-15 m. 2 25 19 59</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 40</b>	20f. (City or town) <b>Elkton</b> (County) <b>Cecil</b> (State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R.C. Dodson</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MARCH 2, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>LAUREL Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>BURLINGTON, New Jersey</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph E. Kicks, Elkton, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAR 4 '59</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneiss</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1911

MASSACHUSETTS

Union Hospital

1911

1911

1911

1911

1911

From the copy under a review

1911

1911

1911

1911

1911

1911

1911



## CERTIFICATE OF DEATH

Reg. Dist. No.

01780

1784

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, Rural</b> c. LENGTH OF STAY IN 1b <b>50 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Aikin</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, Rural</b> d. STREET ADDRESS <b>Aikin</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Howard</b> Last <b>McGuire</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 18, 1883</b> 9. AGE (In years last birthday) <b>75</b> IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stone Mason</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penna. Railroad</b> 11. BIRTHPLACE (State or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James McGuire</b>		14. MOTHER'S MAIDEN NAME <b>Emma Stewart</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>717-07-5276</b> INFORMANT <b>James H. McGuire</b> Address <b>Perryville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>Mild Stroke</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 minutes</b> <b>5 yrs.</b> <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 3, 1954</b> , to <b>Feb 17, 1959</b> , that I last saw the deceased alive on <b>Feb 17, 1959</b> , and that death occurred at <b>2:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Perryville, Md.</b> DATE SIGNED <b>Feb 17, 1959</b>			
ACTUAL SIGNATURE <b>G.H. Richards Jr.</b> M.D.		DATE SIGNED <b>Feb 17, 1959</b>	
PHYSICIAN'S NAME (Type) <b>G.H. Richards Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/19/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Port Deposit, R.F.D., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rebecca Patterson &amp; Son</b>		24a. REC'D BY REGISTRAR <b>FEB 19 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1781

Local

Lebanon, Ohio

50 yrs.

Male

Age

10 yrs.

Married

Married March 12, 1882

Married March 12, 1882

Married

Married

Married

Married

Married

Married

Married

Married

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1764

## CERTIFICATE OF DEATH

Reg. Dist. No.

01781

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kentmore Park, Rural Kennedyville</b> 148-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>				d. STREET ADDRESS <b>Kentmore Park, Rural Kennedyville</b>			
3. NAME OF DECEASED (Type or print) First <b>IVAR</b> Middle <b>MEURLING</b> Last <b>MEURLING</b>				4. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January, 6, 1880</b>		9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanical Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Machine</b>		11. BIRTHPLACE (State or foreign country) <b>Sweden</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edgar Meurling</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Lindebled</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Mildred Meurling, Kennedyville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>446X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Nephrosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Urinary retention due to prostatic hypertrophy</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b> <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 12, 1959</b> to <b>Feb 12, 1959</b> , that I last saw the deceased alive on <b>Feb 12, 1959</b> , and that death occurred at <b>3:02 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Wallace Obenshain, M.D.</b> <b>Cecilton, Md.</b> <b>13 Feb 59</b> PHYSICIAN'S NAME (Type) <b>WALLACE OBENSHAIN CECILTON MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 15, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Crumpton Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Crumpton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Edward Fellowes Mullington, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Thoms</b>	

# CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		DATE OF BIRTH [REDACTED]	
PLACE OF BIRTH [REDACTED]		OCCUPATION [REDACTED]		MARITAL STATUS [REDACTED]	
PLACE OF DEATH [REDACTED]		DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		MEDICAL HISTORY [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF PHYSICIAN [REDACTED]	
SIGNATURE OF JUDGE [REDACTED]		SIGNATURE OF CLERK [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18, Film 282, 3/13/61 - AMS. 1785										BALTIMORE, 18		01782	
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										CERTIFICATE OF DEATH		Reg. Dist. No. 96	
1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>					c. LENGTH OF STAY IN 1b <b>3 mo. 6 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> <b>2212.2</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>					d. STREET ADDRESS <b>211 Calvert</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>(NMI)</b> Last <b>MILES</b>					4. DATE OF DEATH Month <b>February</b> Day <b>16</b> Year <b>19 59</b>								
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-6-93</b>		9. AGE (In years last birthday) yrs. <b>65</b>		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Tabb Miles (Deceased)</b>					14. MOTHER'S MAIDEN NAME <b>Lucy Brown (Deceased)</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW I 219 05 3335</b>		17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of pancreas with wide spread</b> <b>162.1</b> DUE TO <b>with metastasis to bone, lymph nodes, stomach, liver,</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Portal veins thrombosis secondary to above</b> (b) <b>pancreas and left kidney</b> (c) <b>Bronchopneumonia, bilateral, unresolved</b>										INTERVAL BETWEEN ONSET AND DEATH <b>8 months unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>November 10, 19 58</b> , to <b>February 16, 19 59</b> , that I last saw the deceased <b>alive on</b> <b>February 16, 19 59</b> and that death occurred at <b>12:40 a.m.</b> , from the causes and on the date stated above.										ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <b>Bernard S. Lin</b>				M.D. <b>V.A. Hospital, Perry Point, Md.</b>				<b>2-17-59</b>					
PHYSICIAN'S NAME (Type) <b>BERNARD S. LINN, M.D.</b>				Surgical Officer of the Day									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>2-19-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Crisfield</b>		22d. LOCATION (City, town, or county) <b>Crisfield, Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wharton-Savage Fun. Home, New Church, Va.</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>FEB 20 59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Thomas</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1786

## CERTIFICATE OF DEATH

Reg. Dist. No.

01783

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Earleville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Earleville Rural</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GEORGE R. MOFFETT</b>				4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May, 8, 1875</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>24</b> Days <b>19</b> Hours <b>59</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William H. Moffett</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Grady</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-36-8937A</b>		17. INFORMANT <b>William Moffett,</b>		Address <b>Massey, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral thrombosis</b> DUE TO (c) <b>Cerebral arteriosclerosis.</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b> <b>years.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>far advanced senility</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 10</b> , 19 <b>58</b> to <b>Feb 24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>24 Feb</b> , 19 <b>59</b> , and that death occurred at <b>3:30A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cecilton, Md.</b> DATE SIGNED <b>26 Feb 59</b>							
ACTUAL SIGNATURE <b>Wallace G. Obenshain, M.D.</b> M.D. <b>Wallace G. Obenshain, M.D.</b>							
PHYSICIAN'S NAME (Type) <b>Wallace G. Obenshain, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 27, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Old Bohemia Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Warwick, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Holloway</b>				ADDRESS <b>Wellington Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 2 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kane</b>							

CERTIFICATE OF DEATH

1926

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CLERK [Illegible]		SIGNATURE OF WITNESS [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF NEXT OF KIN [Illegible]		SIGNATURE OF BURIAL SOCIETY [Illegible]	
SIGNATURE OF MINISTER [Illegible]		SIGNATURE OF CHURCH [Illegible]		SIGNATURE OF FUNERAL HOME [Illegible]	
SIGNATURE OF HEALTH DEPARTMENT [Illegible]		SIGNATURE OF STATE DEPARTMENT [Illegible]		SIGNATURE OF COUNTY DEPARTMENT [Illegible]	



1787

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>New Castle</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>127 Days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wilmington</b>		46 X - 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>14 Holly Hill Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>J.</b> Last <b>MURPHY</b>		4. DATE OF DEATH Month <b>2</b> Day <b>14</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-4-97</b>
9. AGE (In years last birthday) yrs. <b>61</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PETER MURPHY</b>		14. MOTHER'S MAIDEN NAME <b>NORA DISKEN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>YES</b> <b>WW-1</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>HOSPITAL RECORDS, VAH, PERRY POINT, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1. CORONARY ARTERIOSCLEROSIS (MARKED) WITH CONGESTIVE HEART FAILURE</b> DUE TO <b>2. CEREBRAL ARTERIOSCLEROSIS WITH CEREBRAL ATROPHY AND SECONDARY RIGHT HEMIPLEGIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral Bronchopneumonia</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Over 2 Yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-9-58</b> , 19, to <b>2-14-59</b> , 19, and that death occurred at <b>7:50P</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VA Hospital, Perry Point, Md.</b> DATE SIGNED <b>2-15-59</b>			
ACTUAL SIGNATURE <b>J. C. Grasperger</b> M.D.			
PHYSICIAN'S NAME (Type) <b>J. C. GRASBERGER, M.D. Acting Director, Professional Services</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>2-15-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Long Island National</b>		22d. LOCATION (City, town, or county) (State) <b>Farmingdale, L.I., N.Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington</b> ADDRESS <b>Havre De Grace, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 17 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 ELKTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hosp.</u>		d. STREET ADDRESS <u>102 Mitchell St.</u>	
3. NAME OF DECEASED (Type or print) <u>Ruth</u> First <u>Ritter</u> Middle <u>Ritter</u> Last		4. DATE OF DEATH <u>Feb.</u> Month <u>24</u> Day <u>1959</u> Year	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/23/58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE (In years last birthday) <u>2</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>2</u> Days <u>1</u> Hours <u></u> Min. <u></u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mr. Billie Ritter</u>		14. MOTHER'S MAIDEN NAME <u>Friedhilde Kormelia Schuhmacher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>None</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute viral Gastro enteritis</u> <u>571.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>e Bronchitis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>mild Dehydration and Prematurity</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 23</u> , 19 <u>59</u> , to <u>Feb 23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 23</u> , 19 <u>59</u> , and that death occurred at <u>7:55 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph E. Hibbs</u> M.D.		ADDRESS (Street, city or town, state) <u>245 E. High Street</u> DATE SIGNED <u>3-24-59</u>	
PHYSICIAN'S NAME (Type) <u>Elkton, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Elkton, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hibbs</u> ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 4 '59</u>	24b. REGISTRAR'S SIGNATURE <u>G. E. K.</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1788

## CERTIFICATE OF DEATH

01786

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RISING SUN</u>				c. LENGTH OF STAY IN 1b <u>46 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RISING SUN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>E. MAIN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>AMY VIRGINIA</u> Middle <u>ROBINSON</u> Last				4. DATE OF DEATH Month <u>FEB.</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 27, 1912</u>		9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOOK KEEPER WAREHOUSE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RISING SUN, MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>LEWIS A. CROTHERS</u>				14. MOTHER'S MAIDEN NAME <u>VIOLA M. LYNCH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>164-106366</u>		17. INFORMANT Address <u>CLARA LOVE, CONOWINGO, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Wide spread adeno carcinoma</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>6 mos.</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10/1</u> 19 <u>58</u> , to <u>2/18</u> 19 <u>59</u> , that I last saw the deceased alive on <u>2/18</u> 19 <u>59</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Neil T. [Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>Rising Sun, Md</u> DATE SIGNED <u>2/19/59</u>			
PHYSICIAN'S NAME (Type) <u>N</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FRIENDS</u>		22d. LOCATION (City, town, or county) (State) <u>CALVERT MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M Reed, Rising Sun, Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>FEB 20 '59</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1766

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN TB <u>4</u> days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>T</u> Last <u>Rutter</u>				4. DATE OF DEATH Month <u>2</u> Day <u>4</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 23, 1876</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk Ret. 15 yrs</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Atlas Powder Co</u>		11. BIRTHPLACE (State or foreign country) <u>North East, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>J. Alexander Rutter</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Wingate</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>221-03-0073</u>			
17. INFORMANT <u>Robert C. Reeder Jr</u>				Address <u>339 Little Parkway N. 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric Hemorrhage and Shock.</u> <u>4621</u> DUE TO (b) <u>Hemorrhage from ruptured Esophageal Varices</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Cardio Vascular Disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb 1</u> , 19 <u>59</u> , to <u>Feb 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb. 4, 1959</u> , and that death occurred at <u>9:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. Arthur Cantwell</u>				ADDRESS (Street, city or town, state) <u>North East, Maryland</u>			
DATE SIGNED <u>Feb 9 '59</u>							
PHYSICIAN'S NAME (Type) <u>H. Arthur Cantwell, M.D.</u>				<u>North East, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>North East, Cecil, Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph P. Grant</u>				ADDRESS <u>North East, Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 9 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krasa</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01788

1767

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Chesapeake City</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>				d. STREET ADDRESS <b>1</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>L.</b> Last <b>SHELTON</b>				4. DATE OF DEATH Month <b>February</b> Day <b>27</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 23, 1877</b>		9. AGE (In years last birthday) yrs. <b>81</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Shelton</b>				14. MOTHER'S MAIDEN NAME <b>Sarah L. Registrar</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-22-3583</b>		17. INFORMANT <b>Mrs. Elizabeth Shelton, Chesapeake City, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Occlusion acute</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery diseases.</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>  <b>years.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral inguinal herniae.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Cecilton, Md.</b>		(County) (State)	
21. I certify that I attended the deceased from <b>Feb 25</b> , 19 <b>59</b> , to <b>Feb 27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Feb 27</b> , 19 <b>59</b> , and that death occurred at <b>10:05 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wallace Obenshain</b>				ADDRESS (Street, city or town, state) <b>Cecilton, Md.</b>		DATE SIGNED <b>2 Mar 59</b>	
PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 2, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Chesapeake City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows</b>				ADDRESS <b>Mellington Md</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 4 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

CERTIFICATE OF DEATH

1902

NAME OF DECEASED JOHN		AGE 35		SEX Male		RACE White		DATE OF DEATH Jan 15 1902		PLACE OF DEATH Home	
NATURAL CAUSE OF DEATH Diphtheria		ARTIFICIAL CAUSE OF DEATH None		MANNER OF DEATH Natural		DISEASE OR COMPLAINT Diphtheria		DATE OF ONSET Jan 10 1902		DATE OF DEATH Jan 15 1902	
PLACE OF BIRTH Massachusetts		AGE AT BIRTH 25		SEX Male		RACE White		DATE OF BIRTH Jan 10 1877		PLACE OF BIRTH Massachusetts	
NAME OF DECEASED JOHN		AGE 35		SEX Male		RACE White		DATE OF DEATH Jan 15 1902		PLACE OF DEATH Home	
NATURAL CAUSE OF DEATH Diphtheria		ARTIFICIAL CAUSE OF DEATH None		MANNER OF DEATH Natural		DISEASE OR COMPLAINT Diphtheria		DATE OF ONSET Jan 10 1902		DATE OF DEATH Jan 15 1902	
PLACE OF BIRTH Massachusetts		AGE AT BIRTH 25		SEX Male		RACE White		DATE OF BIRTH Jan 10 1877		PLACE OF BIRTH Massachusetts	
NAME OF DECEASED JOHN		AGE 35		SEX Male		RACE White		DATE OF DEATH Jan 15 1902		PLACE OF DEATH Home	
NATURAL CAUSE OF DEATH Diphtheria		ARTIFICIAL CAUSE OF DEATH None		MANNER OF DEATH Natural		DISEASE OR COMPLAINT Diphtheria		DATE OF ONSET Jan 10 1902		DATE OF DEATH Jan 15 1902	
PLACE OF BIRTH Massachusetts		AGE AT BIRTH 25		SEX Male		RACE White		DATE OF BIRTH Jan 10 1877		PLACE OF BIRTH Massachusetts	



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1789

## CERTIFICATE OF DEATH

01789

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Port Deposit, Rural</u>		LENGTH OF STAY (In this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Port Deposit, Md. Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>Rout 276</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>William</u> (First) <u>Simcoe</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Feb.</u> <u>1</u> <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>March 30, 1883</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Simcoe</u>				14. MOTHER'S MAIDEN NAME <u>Mary Marshall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-18-7236A</u>		17. INFORMANT & ADDRESS <u>R.B. Marshall, Port Deposit, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Myocardial infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary artery Heart disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>2/11</u> , 19 <u>59</u> , to <u>2/11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/11</u> , 19 <u>59</u> , and that death occurred at <u>7:45</u> M., from the causes and on the date stated above.							
SIGNATURE <u>W. C. Conner</u>				ADDRESS (Street, city, town, state) <u>West Nottingham</u>		DATE SIGNED <u>2/3/59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-4-1959</u>		NAME OF CEMETERY OR CREMATORY <u>West Nottingham</u>		LOCATION (City, town, or county) (State) <u>Port Deposit, Md.</u>	
24. REC'D BY REGISTRAR <u>FEB 5 59</u>		REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Conner</u>		ADDRESS <u>Perryville, Md.</u>	
DATE							

# CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
John Doe		Male		45		Jan 1, 1900		New York City		Teacher		Married		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
13. PLACE OF DEATH		14. DATE OF DEATH		15. TIME OF DEATH		16. PLACE OF INTERMENT		17. DATE OF INTERMENT		18. TIME OF INTERMENT		19. NAME OF CEMETERY		20. NAME OF MINISTER		21. NAME OF FUNERAL HOME		22. NAME OF UNDERTAKER		23. NAME OF CARRIER		24. NAME OF DRIVER	
Home		Jan 1, 1950		10:00 AM		New York City		Jan 1, 1950		10:00 AM		New York City		St. John's Church		St. John's Church		St. John's Church		St. John's Church		St. John's Church	

NOTATION

This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his or her illness or who has attended the deceased at the time of death. It is to be filled out in duplicate and one copy is to be retained by the physician or other qualified person and the other copy is to be forwarded to the Registrar of the Department of Health, Baltimore, Maryland. The certificate is to be filled out in English and in the language of the deceased if the deceased is not a native-born American citizen. The certificate is to be filled out in duplicate and one copy is to be retained by the physician or other qualified person and the other copy is to be forwarded to the Registrar of the Department of Health, Baltimore, Maryland. The certificate is to be filled out in English and in the language of the deceased if the deceased is not a native-born American citizen.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1790

## CERTIFICATE OF DEATH

Reg. Dist. No.

01790

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun Rural</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>McCall</u> Last <u>Simmers</u>		4. DATE OF DEATH Month <u>February</u> Day <u>26</u> Year <u>19 59</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1872</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Anderson McCall</u>		14. MOTHER'S MAIDEN NAME <u>Hettie Lackland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Robert Simmers</u>		Address <u>Rising Sun, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cronic Myocardicis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arterio Sclerosis</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>19 59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1958</u> , 19 <u>  </u> , to <u>Feb 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 25</u> , 19 <u>59</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rising Sun, Maryland</u> DATE SIGNED <u>  </u>			
ACTUAL SIGNATURE <u>R. C. Dodson</u> M.D.		DATE SIGNED <u>  </u>	
PHYSICIAN'S NAME (Type) <u>R. C. Dodson</u>		DATE SIGNED <u>  </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 1-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u>		22d. LOCATION (City, town, or county) (State) <u>Rising Sun, Cecil Co., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>		ADDRESS <u>north East mo</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Orlino S. Hanna</u>	

CERTIFICATE OF DEATH

1900

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		MARRIED		USUAL RESIDENCE		DECEASED AT	
JAMES H. HARRIS		Male		45		Jan 15, 1855		Baltimore, Md.		Yes		Baltimore, Md.		Baltimore, Md.	
OCCUPATION		CAUSE OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE	
Carpenter		Heart Disease		2 weeks		Home		100° F		80		24		120/80	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE		SIGNATURE OF PHYSICIAN	
Jan 20, 1900		10:00 AM		Home		100° F		80		24		120/80		J. H. Harris	
DATE OF INTERMENT		TIME OF INTERMENT		PLACE OF INTERMENT		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE		SIGNATURE OF CLERK	
Jan 22, 1900		10:00 AM		Home		100° F		80		24		120/80		J. H. Harris	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01791

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edelton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edelton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>		d. STREET ADDRESS <i>Ed #3 Edelton</i>	
3. NAME OF DECEASED (Type or print) First <i>Virginia</i> Middle <i>Christine</i> Last <i>Smith</i>		4. DATE OF DEATH Month <i>2</i> Day <i>25</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-25-59</i>
9. AGE (In years lost birthday) yrs. <i>6</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>6</i> Days <i>00</i> Hours <i>00</i> Min. <i>00</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Edelton Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert Lee Smith</i>		14. MOTHER'S MAIDEN NAME <i>Mary Elizabeth Wyant</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Robert Lee Smith</i>		Address <i>Ed #3 Edelton</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular failure</i> <i>762.5</i> DUE TO <i>Respiratory failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Prematurity</i> (c)			INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i> <i>5 hrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>2-25-59</i> , 19 <i>59</i> , to <i>2-25-59</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>2-25-59</i> , 19 <i>59</i> , and that death occurred at <i>5:00 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>North East, Md.</i> DATE SIGNED			
ACTUAL SIGNATURE <i>Luis M. Cuza</i> M.D.			
PHYSICIAN'S NAME (Type) <i>Luis M. Cuza</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-26-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Edelton Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Edelton Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Walter duBois</i> ADDRESS <i>Edelton</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 2 '59</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

2065202XV0

CERTIFICATE OF DEATH

Page No. 18

DECEASED'S NAME		DATE OF DEATH	
SEX		AGE	
RACE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
MANNER OF DEATH		CAUSE OF DEATH	
DISEASE		SYMPTOMS	
TREATMENT		HISTORY	
FAMILY HISTORY		PREVIOUS ILLNESS	
MEDICAL HISTORY		LABORATORY TESTS	
PATHOLOGICAL FINDINGS		MICROSCOPIC EXAMINATION	
GROSS EXAMINATION		HISTOCHEMICAL EXAMINATION	
IMMUNOLOGICAL EXAMINATION		BACTERIOLOGICAL EXAMINATION	
VIROLOGICAL EXAMINATION		PARASITOLOGICAL EXAMINATION	
TOXICOLOGICAL EXAMINATION		RADIOLOGICAL EXAMINATION	
CYTOLOGICAL EXAMINATION		GENETIC EXAMINATION	
ANTHROPOLOGICAL EXAMINATION		FOUNDED BY	
REVIEWED BY		APPROVED BY	
DATE		SIGNATURE	



1. This is a copy of the original record of the death of the deceased, as reported by the attending physician or other person having knowledge of the facts, and as the same may be corrected or amended by the State Department of Health, Baltimore, Maryland, at any time, and the same may be corrected or amended by the State Department of Health, Baltimore, Maryland, at any time, and the same may be corrected or amended by the State Department of Health, Baltimore, Maryland, at any time.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1769

## CERTIFICATE OF DEATH

Reg. Dist. No.

01792

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 10 Min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hosp.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City, X			
4. DATE OF DEATH February 20 1959				d. STREET ADDRESS Lewis Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JAMES ALBERT STAPP				4. DATE OF DEATH February 20 1959			
5. SEX Male				6. COLOR OR RACE White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Oct. 30, 1893			
9. AGE (In years last birthday) 65 yrs.				IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maint. Supt.				10b. KIND OF BUSINESS OR INDUSTRY C. and D. Canal			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edward Stapp				14. MOTHER'S MAIDEN NAME Mary Krastel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW 1				16. SOCIAL SECURITY NO. 169-20-1586			
17. INFORMANT Mrs. Mildred R. Stapp				Address Ches. City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Thrombosis DUE TO (b) Chronic myocarditis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH on hour one year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 14 1958 to Feb 20 1959, that I last saw the deceased alive on Feb 20 1959, and that death occurred at 11:40 M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED 2/20/59			
ACTUAL SIGNATURE Henry J. Davis M.D.				PHYSICIAN'S NAME (Type) HENRY J. DAVIS MD CHESAPEAKE CITY MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/24/1959			
22c. NAME OF CEMETERY OR CREMATORY St. Roses Cemetery				22d. LOCATION (City, town, or county) (State) Chesapeake City, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home				24a. REC'D BY REGISTRAR DATE FEB 24 59			
24b. REGISTRAR'S SIGNATURE							

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1791

CERTIFICATE OF DEATH

Reg. Dist. No. 97

01793

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bainbridge</b>				c. LENGTH OF STAY IN 1b <b>10 minutes</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>Ellen</b> Last <b>Vasco</b>				4. DATE OF DEATH Month <b>February</b> Day <b>14</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>14 February 1959</b>		9. AGE (In years last birthday) yrs. <b>10</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Joseph Anthony Vasco</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Jane Kahn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Hospital Record</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>761.0 PREMATURE SEPARATION OF PLACENTA</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>14 February, 1959</b> to <b>14 February 1959</b> , that I last saw the deceased alive on <b>14 February, 1959</b> and that death occurred at <b>9:15 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Richard B. Speaker</b> M.D.							
PHYSICIAN'S NAME (Type) <b>RICHARD B. SPEAKER LCDR MC USN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/19/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LEE A. PATTERSON &amp; SON</b> ADDRESS <b>PERRYVILLE, MD.</b>				24a. REC'D BY REGISTRAR <b>FEB 19 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1792 CERTIFICATE OF DEATH

01794  
96

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>CHESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PERRY POINT</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OXFORD</b> <b>75 X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>27 North 4th Street</b>	
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>D.</b> Last <b>WALKER</b>		4. DATE OF DEATH Month <b>February</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 6, 1881</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Army Officer</b>	
11. BIRTHPLACE (State or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FRANKLIN WALKER</b>		14. MOTHER'S MAIDEN NAME <b>LOUISA FITE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW-I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records, VA Hospital, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Generalized marked arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 6, 1958</b> , to <b>February 23, 1959</b> , and that death occurred at <b>2:10 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VA Hospital, Perry Point, Md.</b> DATE SIGNED <b>2-23-59</b> ACTUAL SIGNATURE <b>R. BURKE SUTT</b> M.D. PHYSICIAN'S NAME (Type) <b>R. BURKE SUTT, M.D., Acting Director, Professional Services</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>2-24-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New London</b>		22d. LOCATION (City, town, or county) (State) <b>New London, Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PHILIP M. HAYRE</b>		ADDRESS <b>Havre DeGrace, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

# CERTIFICATE OF DEATH

STATE OF NEW YORK

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01795

1770

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 1 Month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Elk Mills	
		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Essie R. Watts		4. DATE OF DEATH Month Day Year February 13 1959	
5. SEX F	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1883
		9. AGE (In years last birthday) yrs. 75	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY House Work	11. BIRTHPLACE (State or foreign country) Havre De Grace, Md.
13. FATHER'S NAME No Information		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14. MOTHER'S MAIDEN NAME Margaret No Information			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Helen G. Wiley		219 W. 4th Place Newark, Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Osteoporosis of spine with collapse of lumbar vertebrae			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Nat while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 8, 1959, to Feb. 13, 1959, that I last saw the deceased alive on Feb. 13, 1959, and that death occurred at 11:30 PM, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE S. Ralph Andrews, Jr., M.D.		233 E. Main Street 2/14/59	
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.		Elkton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-17-1959	22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Pk.	22d. LOCATION (City, town, or county) (State) R. D. Elkton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Pippin Funeral Home		24a. REC'D BY REGISTRAR FEB 19 1959	24b. REGISTRAR'S SIGNATURE Arthur E. Knapp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

01796

1771

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. LENGTH OF STAY IN 1b <u>2 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON RURAL</u>			
				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Diane</u> Middle <u>E</u> Last <u>White</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-31-1955</u>	
9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>-</u>							
13. FATHER'S NAME <u>RICHARD E. WHITE</u>				14. MOTHER'S MAIDEN NAME <u>POLLY ANN SPENCE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Richard E White Elkton RD Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Lobar Pneumonia</u> <u>590X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Upper Resp. Infection</u> DUE TO (c) <u>Acute Nephritis</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>3 wks</u> <u>1 wk?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARDIAC FAILURE</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8 Feb</u> , 19 <u>59</u> , to <u>9 Feb</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9 Feb</u> , 19 <u>59</u> , and that death occurred at <u>9:40 P</u> .M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Elkton, Md</u> DATE SIGNED ACTUAL SIGNATURE <u>George J. Kreis, Jr.</u> M.D. PHYSICIAN'S NAME (Type) <u>George J. Kreis, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-12-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>North East Cecil Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R Grant North East Md</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		12-1-28		MOBILE, ALABAMA	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MARRIED		12-1-52		BALTIMORE, MD		4-6-68		BALTIMORE, MD		HEART DISEASE	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
CONTRACTOR		12-1-52		BALTIMORE, MD		4-6-68		BALTIMORE, MD		HEART DISEASE	
EDUCATION		DATE OF EDUCATION		PLACE OF EDUCATION		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
HIGH SCHOOL		12-1-52		BALTIMORE, MD		4-6-68		BALTIMORE, MD		HEART DISEASE	
RELIGION		DATE OF RELIGION		PLACE OF RELIGION		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
METHODIST		12-1-52		BALTIMORE, MD		4-6-68		BALTIMORE, MD		HEART DISEASE	
PREVIOUS ILLNESS		DATE OF PREVIOUS ILLNESS		PLACE OF PREVIOUS ILLNESS		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
NONE		12-1-52		BALTIMORE, MD		4-6-68		BALTIMORE, MD		HEART DISEASE	
TREATMENT		DATE OF TREATMENT		PLACE OF TREATMENT		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
NONE		12-1-52		BALTIMORE, MD		4-6-68		BALTIMORE, MD		HEART DISEASE	
BURIAL		DATE OF BURIAL		PLACE OF BURIAL		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
NONE		12-1-52		BALTIMORE, MD		4-6-68		BALTIMORE, MD		HEART DISEASE	
SIGNATURE		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JAMES EARL RAY		12-1-52		BALTIMORE, MD		4-6-68		BALTIMORE, MD		HEART DISEASE	
WITNESSES		DATE OF WITNESSES		PLACE OF WITNESSES		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
NONE		12-1-52		BALTIMORE, MD		4-6-68		BALTIMORE, MD		HEART DISEASE	
DOCTOR		DATE OF DOCTOR		PLACE OF DOCTOR		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
NONE		12-1-52		BALTIMORE, MD		4-6-68		BALTIMORE, MD		HEART DISEASE	
CORONER		DATE OF CORONER		PLACE OF CORONER		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
NONE		12-1-52		BALTIMORE, MD		4-6-68		BALTIMORE, MD		HEART DISEASE	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, 18

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Reg. Dist. No.

1793

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>127 N. Main St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Wesley</b> Last <b>Williams</b>		4. DATE OF DEATH <b>Feb.</b> Month <b>13</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 17, 1876</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. UNDER 1 YEAR Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min.	11. UNDER 24 HRS. Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fire Fighter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U S V. Hospital.</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John W. Williams</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Norris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-09-6226</b>	
17. INFORMANT <b>Minnie B. Williams</b>		Address <b>Port Deposit, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO <b>Paralysis left side and blind -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Sclerosis</b> DUE TO <b>Arterio-Sclerosis - Hypertension</b> (c) <b>Arterio-Sclerosis - Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days -</b> <b>4 yrs</b> <b>7 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb - 8</b> , 19 <b>59</b> , to <b>Feb 12</b> , 19 <b>59</b> . That I last saw the deceased alive on <b>Feb - 12</b> , 19 <b>59</b> , and that death occurred at <b>5:15 A.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Port Deposit</b> DATE SIGNED <b>2/14/59</b>	
ACTUAL SIGNATURE <b>Clarence I. Benson</b> M.D.		PHYSICIAN'S NAME (Type) <b>Clarence I. Benson M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-15-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hopewell</b>		22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Sons</b> ADDRESS <b>Perryville, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 16 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

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DEATH

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